

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010667</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/04/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>STERLING HOUSE OF SOUTH BEND</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>17441 SR 23</b> <b>SOUTH BEND, IN 46635</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00135866.</p> <p>Complaint IN00135866-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: October 3 and 4, 2013</p> <p>Facility number: 010667 Provider number: N/A AIM number: N/A</p> <p>Survey team: Julie Baumgartner RN-TC Shelly Vice RN Sharon Ewing RN</p> <p>Census bed type: Residential: 43</p> <p>Census Payor type: Other: 43</p> <p>Sample: 3</p> <p>Sterling House was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00135866.</p> <p>Quality Review 10/07/13 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE